


Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER TN8602	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 04/14/2011
NAME OF PROVIDER OR SUPPLIER UNICOI CO NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GREENWAY CIRCLE ERWIN, TN 37650	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
N 000	Initial Comments An annual Licensure survey was conducted April 12-14, 2011, at Unicoi County Nursing Home. No deficiencies were cited under Chapter 1200-08-06, Standards for Nursing Homes.	N 000	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

 CED, NHA
TITLE

(X6) DATE

4/21/11

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If continuation sheet 1 of 1